COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MEETING MINUTES
June 2-3, 2014

Meeting Location: University of Texas at San Antonio, Downtown Campus
501 W. César E. Chávez Blvd
Southwest Room, Durango Building 1.124
San Antonio, Texas 78207

Commissioners Present: David Sanders, Amy Ayoub, Cassie Statuto Bevan, Theresa Covington, Wade Horn, Patricia Martin, Michael Petit, Jennifer Rodriguez, David Rubin, Marilyn Zimmerman. Bud Cramer and Susan Dreyfus were not in attendance.

Designated Federal Officer: Liz Oppenheim, Chief of Staff

Conduct of the Meeting: In accordance with the provisions of Public Law 92-463, the Commission to Eliminate Child Abuse and Neglect Fatalities held a public meeting on Monday, June 2, 2014, from 1:00 p.m. – 5:30 p.m., and Tuesday, June 3, 2014, from 8:30 a.m. – 1:00 p.m., at the University of Texas at San Antonio, Downtown Campus. The purpose of the meeting was for Commission members to gather national and state-specific information regarding child abuse and neglect fatalities. The Commission heard from researchers and issue experts regarding the scope of the problem, strategies for improving national data collection, policy barriers and opportunities to reduce maltreatment fatalities, confidentiality issues, and potential solutions. Experts from such disciplines as child welfare, law enforcement, health, and public health presented strategies for addressing the issue of child abuse and neglect fatalities.

Chairman Sanders informed participants that the agenda was very tight and that he was going to keep closely to the times allotted for each presentation. He indicated that audience members would not have the opportunity to ask questions during the proceedings and requested that audience members not engage in direct dialogue with the Commissioners. Finally, he indicated that any audience members wishing to comment could leave written testimony in the designated file at the registration table or submit testimony or written feedback through the Commission's website.

Monday, June 2, 2014

OPENING REMARKS

Chairman David Sanders

Chairman Sanders began by recognizing that this is the Commission's first field meeting and thanking Congressman Lloyd Doggett for inviting the Commission to Texas. The Commission was created by the Protect Our Kids Act in 2013, and during the next year and a half it will engage in a national dialogue on child abuse and neglect fatalities through hearings like this one. Eventually, the Commission will produce a report for the President and Congress. Chairman Sanders laid out the following goals of the Commission:

- Gain an understanding of how determinations are made regarding whether a child fatality is due to abuse and neglect, and how fatalities and related information are captured in different data systems.
- Determine how best to measure the number of fatalities due to abuse and neglect.
- Understand what works and what doesn't and how Congress and the administration can support what works and not waste resources on what doesn't.

This meeting will include presentations on relevant child welfare policy, research regarding how we count and what we count, and state practice. According to data from the national Child Abuse and Neglect Data System (NCANDS), the state of Texas has the highest absolute number of fatalities in the country. Texas does not, however, have the highest rate of fatalities (fatalities per 10,000 children). Bexar County has seen a sharp decline during the past year in the number of child maltreatment fatalities. During this meeting, we will hear about what is working and what is not working in Texas, how fatalities are counted, and how the state addresses issues of confidentiality.

Chairman Sanders announced that the Commission launched its website launched today at https://eliminatechildabusefatalities.sites.usa.gov. He noted there are 100 members of the public present or participating in the meeting by phone, and that while there will not be an opportunity for public comment at the meeting, feedback may be submitted in writing via the "Contact Us" section of the website.

Chairman Sanders asked all of the Commissioners in the room to introduce themselves. Each Commissioner provided some background information.

NATIONAL RESEARCH, POLICY, AND PRACTICE

What We Count

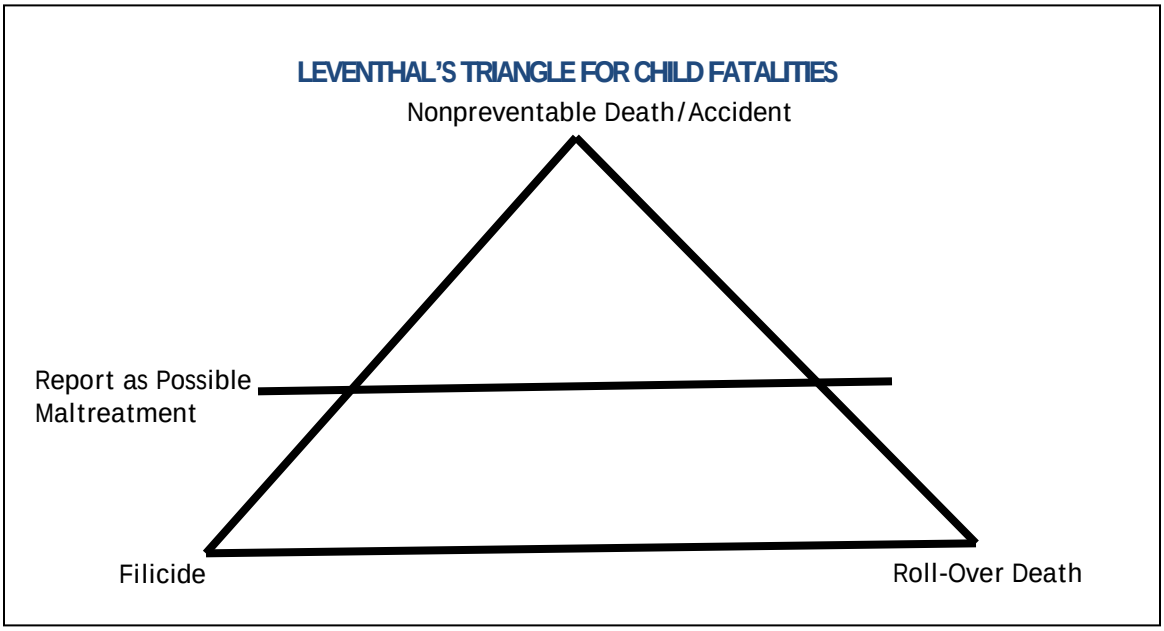
Dr. Rachel Berger, Pediatrician and Chief of the Children's Hospital, Pittsburg Child Advocacy Center; research staff for CECANF

Dr. Berger presented on the topics of what we count, why we should count, and why counting matters. Key points of her presentation include the following:

- Question: What is a death due to child maltreatment and who decides?
- CAPTA defines a maltreatment death as "Any recent act or failure to act on the part of a parent or caretaker which results in death." This seems straightforward, but

every word is subject to interpretation (for example, what is "recent?").

- Who decides whether a death is due to maltreatment varies depending on where the child lives. In some states (e.g., Alaska), it's the medical examiner; in others (e.g., New Jersey), the CPS director.
- Question: How sure do you have to be to call something abuse?
  - 36 states use "preponderance of the evidence"; other states use "credible" or "reasonable" evidence; some use "clear and convincing evidence." All are below the threshold for criminal behavior that requires "beyond a reasonable doubt."
  - Pennsylvania has been using "clear and convincing," but new legislation as of January 2015 will revert back to a lower standard. As a result, the number of deaths due to maltreatment likely will increase.
- Professor John Leventhal's Triangle helps physicians think about and explain decisions on cases. It is a tool to analyze where a person fits on the spectrum of the various decisions to determine a child fatality. At the top of the triangle is nonpreventable, clearly accidental death—everyone agrees. At the bottom, on one side is filicide (clearly maltreatment) and the other is unsafe sleep deaths. Question: Where is the line for determining a child maltreatment fatality, and are the lines different for abuse vs. neglect? Where we put it will greatly impact the numbers. If we don't agree where the line is, everyone is counting different things.



- Questions arising in counting different types of abuse:
  - **Deaths due to physical abuse**: States and localities may look at whether the parent showed remorse, had prior contact with CPS, or has other children in the home, as well as what the coroner says and whether the perpetrator is prosecuted and/or convicted. Many states don't "count" a death as maltreatment if there has been no prior CPS involvement. (Dr. Berger argued that all should be counted.)
  - **Supervisory neglect:** These are deaths resulting from such things as fire, drowning, falls, and exposure to heat and cold. There are many questions about the line between accident and neglect. Factors may include age, time alone, substance use, or local norms. Does it need to be a pattern or one egregious act enough? Does

prior CPS involvement matter?

- **Medical neglect**: This is the failure to heed obvious signs of a serious illness or failure to follow a physician's recommendation. Questions: What role does religion play, or lack of trust in physicians based on prior experiences? Is cognitive impairment of caregivers relevant?
- **Unsafe sleep**: Increasingly, states are counting sleep deaths as neglect. There has been a shift in the cultural norm—it is no longer considered safe or acceptable to place a baby to sleep on his stomach. This change leads to increased counting of sleep deaths as neglect.

- These questions about counting are important. To implement evidence-based interventions and know whether the number of deaths is truly going down, you have to have consistent data about all deaths.
- To get the information we need, we need a data system that is child-centric and includes the circumstances of the death. One cannot determine whether something counts as maltreatment based on whether investigators could see how it could happen to them, because the death is "punishment enough" for the parents, or because systems or programs do not want to be blamed.
- In the current system, submission of data to the National Child Abuse and Neglect Data System (NCANDS) is voluntary; CAPTA encourages but does not require interdisciplinary reviews; and there are huge fluctuations in what is counted based on jurisdiction. As a result, there is tremendous variation in what "counts" in different jurisdictions, depending on, for example, whether the perpetrator is identified, whether siblings were present, and whether the family had prior involvement with CPS.
- We need to develop consensus at the federal level about what "must be counted" and recognize that the problem will look worse when definitions become more inclusive and consistent. For example, the CDC had an expert panel devise a system of coding with both broad and narrow definitions of abusive head trauma; this could serve as a model for child abuse and neglect. Counting may need to be independent of whether CPS substantiates a case.
- Near fatalities also should be captured, because the risks in the family may be exactly the same, but for unrelated reasons, one child dies, but the other doesn't. CAPTA requires that for an event to be classified as near fatality, it must be "certified by a physician that the child is in serious or critical condition." Each word is fraught with similar issues of definitions and interpretation.

Commissioner Discussion

Issues and questions raised by Commissioners in response to this presentation include the following:

- Recent research by Emily Putnam-Hornstein has called into question prior beliefs that race affects whether cases are indicated.
- The value of our current data is low, but we really do not know how inaccurate our current data are. We only know certain risk factors that seem to be related to death—the single most important being a report to CPS in a child under age 5. If you actually had the true number of deaths—3,000 or 4,000 per year—we might have enough data to look at predictive values. Lots of factors are considered as part of a death review, but in NCANDS we merely get abuse or neglect label.

- We need to keep in mind for whom we are counting and for what purpose. Currently, we use more CPS-oriented definitions; NCANDS is a CPS-based system. The implication is that when a child dies, CPS did something wrong, which puts emphasis on one system, but many systems are involved with families: doctors, schools, and law enforcement also need attention.
- Predictive factors from a national counting system may have limited value—e.g., not everyone who uses drugs kills their baby. A local organization of interdisciplinary teams may be key to how best to respond within a local community.
- Some combinations of risk factors may be particularly toxic. A larger data set may yield this information.

- Including near-fatality, preventable deaths would be another way to increase the size of the data set.

How We Count

Dr. Sam Gulino, Pennsylvania Medical Examiner's Office

Dr. Gulino discussed the mechanics of counting and suggestions for how the national count might be improved. Key points of his presentation include the following:

- The official number of children who die each year of child abuse and neglect comes from NCANDS and ranges from 1,550–1,750 per year. In 2012, 1,640 children died from maltreatment. We know that not all deaths are currently captured, due in part to the following challenges of NCANDS:
  - Reporting is voluntary.
  - Historically, half the reporting states base their count solely on child welfare data. This creates an undercount because not all children who die from abuse and neglect were previously known to child welfare, not all have siblings that require protection, other agencies do not always cross-report to child welfare, etc. NCANDS only captures data on fatalities that are reported to the child welfare agency.
  - NCANDS captures individual cases into what is known as the Child File. These are cases that are reported to child welfare and are reviewed and determined to be due to abuse or neglect by child welfare. The Agency File provides data voluntarily submitted to the child welfare agency from other sources including law enforcement and vital statistics.
  - For the states that do not report, NCANDS uses the count from reporting states to generate a national estimate based on population. Therefore, you get estimates based on estimates, which is a statistical nightmare and relies on incorrect assumptions of commonalities among states.
- From a public health perspective, we need to be able to measure a problem to see whether interventions are working.
- We do not know by how much NCANDS undercounts child fatalities. In 2008, Patricia Schnitzer looked at maltreatment ascertainment in California, Michigan, and Rhode Island, and found an undercount of fatal child maltreatment between 55 percent and 76 percent, based on looking at other sources of child fatality data.

- Available data sources for counting fatal child maltreatment include the following:
  - **Child welfare data**. Some of the challenges:
    - May only capture families with child welfare history.
    - Some states do not count if the perpetrator is not identified or not a parent.
    - May not count if there is no sibling in the home.
    - Chronic undercount of neglect.
  - **Death certificate data.** Advantage: Most people who die get death certificates. Challenges:
    - Death certificates can miss up to 90 percent of fatal maltreatment cases.
    - Incorrect completion of death certificates is common (no training in medical school).
    - There are inconsistent standards for death certificates—some have check boxes, which help standardization, but they usually don't include a specific box for child abuse.
  - **FBI Uniform Crime Report (UCR) data on homicides**. Challenges:
    - UCR data can miss up to 85 percent of child maltreatment data because not all states require reporting from every municipality.
    - Many neglect cases do not lead to criminal charges.
  - **Child fatality review data**. Challenges:
    - Not all states review all child deaths.
    - Not all states contribute to the national case reporting system.
    - Child death review teams have varying expertise.
    - Definitions are not applied consistently from team to team.
- Case ascertainment can be tremendously enhanced when multiple data sources are used. For example, California counts a case as a child maltreatment death if called so by the coroner, law enforcement, or by child welfare.
- Combining data sources for counting was one of the recommendations in the 2011 GAO report. The Child and Family Services Improvement and Innovation Act of 2011 requires states to disclose their data sources and explain why others weren't used, but they are not required to use multiple sources.
- Using death certificates may be the most promising source to improve counting because almost every child who dies gets a death certificate. In a current study, Patricia Schnitzer is matching child death review data with death certificate data from nine states for children ages 1 week to 4 years, for deaths occurring between 2009 and 2010. She is trying to develop a better way to pull child maltreatment data out of death certificates.
- Child death review (CDR) is another method that could improve counting. It is known that ascertainment improves when you combine CDR data with another source. Reasons this makes sense:
  - Every state and Washington, DC have CDR.
  - CDR teams often include child maltreatment specialists.
  - This would involve expanding and improving existing structures, instead of creating new ones.
- It would be difficult to have a uniform definition for child maltreatment across disciplines, but you could have a consensus definition specifically for child death

review, separate and apart from child welfare or criminal definitions.

- Creating a uniform definition of physical abuse raises some questions but is generally less problematic than a uniform definition of neglect. It can be difficult to distinguish between "small-n neglect" (things that we accept happen because we are imperfect human beings) and "capital-n Neglect" (egregious lapses by caretakers). The CDC tried to create standard definitions but still had too many subjective terms.
- Amy Smith Slep and Rick Heyman from SUNY Stony Brook created a system to assist the Air Force in making determinations of child abuse. The Air Force has both community maltreatment decision committees and master reviewers who determine substantiation, but these groups did not always agree. They created a computerized decision tree that breaks down the determinations from "Is this child abuse?" to smaller questions such as, "Did this condition or specific behavior exist?" After the community decision boards started using it, there was much more agreement.
- One potential way to improve counts would be to use multiple data sources to identify potential cases and using CDR teams to evaluate, categorize, and count the deaths. This would require: (1) creating agency-independent definitions of fatal child maltreatment that can be applied universally, and (2) using a Heyman/Slep-like tool to improve agreement among teams.
- Concerns about using death certificates to improve counting:
  - Compliance rate for filling them out is high, but incompleteness is a problem. Two sections impact identification of child maltreatment: "Cause of Death" and "How Injury Occurred."
  - Based on the descriptions the physicians write, the boxes are given an ICD code describing why the person died. It takes very careful wording on the certificate to get the correct code for child abuse death, which is why so many are missed.
  - For most violent and suspicious deaths, death certificates are filled out by medical examiners or coroners who may not properly investigate and certify all these deaths.
  - Medical examiners are medical doctors trained in forensic pathology, whereas coroners (who conduct 70 percent of death investigation) are typically not required to have this training. They are elected officials. Who you have varies according to state statute. Many coroners work in smaller rural areas with extremely few child abuse fatalities. They may hire forensic pathologists, but the coroner is not bound by their determination.
- A possible solution to these difficulties is to transition to a medical examiner system across all states and regulate investigations with clear standards. This would require creation of a model statute to be adopted by all states, expansion of pathology training programs, and increases to medical examiner facilities' equipment, staff, and training.
- Short-term solutions:
  - Create a nationally standardized death investigation tool.
  - Require coroners to provide forensic pathologists all available investigative information.
  - Require coroners to defer to forensic pathologists in determining cause and manner of death.

Commissioner Discussion

Issues raised during discussion with Commissioners in response to this presentation include the following:

- A case cannot be investigated and ascertained by anyone other than a medical professional. Jurisdictions need medical examiners specifically trained to investigate these cases. Actually filling out the death certificate can be taught to anyone with the skill set to understand it.
- The Commissioners expressed interest in the potential of the Slep/Heyman tool developed for the Air Force because it takes a lot of the judgment and subjectivity out of the decision-making.
- The national count of child maltreatment deaths should represent the best number that we can identify, even if it is not perfect.
- There are no current standards for conducting a high-quality autopsy and death investigation to ascertain maltreatment. These could be developed based on current sleep death protocols.
- A standard investigative tool would not rely on a national definitions; it would be a map for the investigator of how to conduct interviews, scene investigations, etc. The determination of whether a death was due to child abuse might require definitions, but the investigation tool would not.
- We need definitions that are divorced from agency-specific definitions, across states: If it meets the national criteria, it is counted, regardless of whether it would be prosecuted as a crime, substantiated by child welfare, etc. We could end up with two counts: national count and NCANDS.
- The database from the National Center for Child Death Review could improve the reliability of their numbers if states changed their statutes to require review of all deaths, or at least all with a suspicion of maltreatment, and you had a tool like the Heyman/Slep tool to break down decisions.

PRACTICE IN TEXAS

Dr. Martell Teasley, Professor and Chair, University of Texas at San Antonio, Department of Social Work in the College of Public Policy

Dr. Martell Teasley is the editor of the journal, *Children in Schools*, and his research concerns how schools impact the socialization of children. He asserted that we need a cultural shift to a society that is much more child-focused and child-centered.

Dr. Teasley advocated that all children coming into the foster care system should receive trauma-informed assessments in addition to psychosocial assessments. Kids who have experienced trauma are dramatically more likely to develop antisocial outcomes such as substance abuse, truancy, and bullying. Kids in foster care are likely to have experienced high levels of trauma, but the system is not intervening. House Bill 1143 would have required that all children coming into foster case receive a trauma-informed assessment within 45 days and trauma-informed interventions. Dr. Teasley advocated in support of that legislation.

State Senator Carlos Uresti

Senator Carlos Uresti has been a senator for nine years and was a state representative for eight years. He currently sits on the Senate Health and Human Services Committee; he is a former chair of that committee. Key points from his presentation:

- In Texas last year, there were 66,000 victims of child abuse or neglect and 156 children lost their lives. CPS has initiated a more rigorous statistical and data-driven analysis of those deaths to identify trends that might be used to aid in prevention.
- TexProtects funds home visitation as a prevention program. According to the Rand Corporation and the Washington State Institute for Public Policy, proven home visitation programs can save from $1.18 up to $14.65 for every dollar spent.
- Senator Uresti authored SB 769 in 2013, which provided wraparound services to foster families with severely traumatized or special needs children.
- "What works": Advocacy through Commissions like this one and their own Bexar County and Statewide Blue Ribbon Task Forces. "What doesn't work": Slashing prevention budgets. Prevention currently makes up only 5 percent of the state's DFPS budget.
- When asked what he attributes the recent decline in child deaths to (from 229 two years ago to 156 last year), Sen. Uresti answered that he was not sure. He identified advocacy groups and prevention programs doing a better job as possibilities.

Judge John Specia, Commissioner, Texas Department of Family and Protective Services

Judge Specia has been Commissioner for about 1 1/2 years, and prior to that was the District Court Judge in Bexar County for 18 ½ years, supervising all child abuse and neglect cases. He also served on the Board of the National Council of Juvenile and Family Court Judges. He co-chaired the State Blue Ribbon Task Force with Senator Uresti. Key points from his presentation:

- First Judge Specia made a correction: there were 212 deaths 2 years ago, down to 156.
- The community regularly comes together to look at what they can do better. They currently are focusing on a public health approach with their Be On the Lookout campaign, which focuses on safe sleep, drowning, and hot cars, with posters all over the city.
- He then gave an overview of Texas system:
  - Texas is a state-based child welfare system with about 400 employees. Child protective services is part of their Health and Human Service Commission.
  - It handles all calls of abuse and neglect for children, the elderly, and the disabled. Their hotline received 730,000 calls last year, and more than 229,000 were sent to CPS for investigation.
  - He also supervises the Community Care Licensing, which regulates childcare facilities. If we are going to reduce fatalities, we have to focus on childcare licensing. Parents are attracted to illegal care because it is cheaper, but there are a multitude of unsafe practices, including unsafe sleep, inadequate supervision (sometimes ratios of 1 to 44), and unsupervised pools.
  - All deaths of children under 6 years old must be reported to the county medical examiner. All fatalities where abuse or neglect is suspected must be investigated. DFPS reports all confirmed abuse and neglect-related fatalities.

- In the past fiscal year, the number of child maltreatment fatalities has dropped, and Judge Specia has been assured that they are counting the same way. He can't say why the numbers are dropping, but he hopes it is from community awareness and efforts by the state and nonprofits.
- Of child maltreatment fatalities in Texas, 81% of children who died were 3 years old or younger and 50% were male; 59% of fatalities were due to neglect rather than abuse, including lack of medical care, firearms safety, and drowning; and 89 of the 156 fatalities were not known to CPS. In the past four years, the number of intentional physical abuse fatalities has dropped by 30%.
- Texas has changed its system of data collection and is trying to make sure data are collected the same way every year.
- After reviewing the fatalities in 2013, they found that the lack of protective capacity of the caregivers is a major risk factor. As a result, they are increasing the number of safety checks for children under age 3, those over whom the state has conservatorship, and those in foster care or kinship care for unfenced swimming pools, accessible firearms, and family violence issues.
- A new program called Project Hit is providing preventive services to families who have previously had their parental rights terminated due to child abuse and neglect and who currently have a newborn, as well as current foster children who are pregnant or have given birth in the last four years.
- The Commission could help efforts in Texas by supporting: consistent data across jurisdictions, more flexibility in federal funding, and more funding for prevention.

Commissioner Discussion

Issues raised during discussion with Commissioners in response to this presentation include the following:

- Last year there was a decrease in the number of deaths overall, but a significant increase in the number of deaths of children in conservatorship or foster care. DFPS changed licensing rules, required more reference checks, increased safety checks, and made more unannounced visits to help protect children from drowning, firearm injury, and unsafe sleep. They are also training workers how to recognize and address family violence.
- There are 28,000 kids in foster care on any given day; 10,000 of these children are in kinship care. There had been an attitude to leave kinship caregivers alone because they were stepping up to take in their relatives, but the state has to be more aware of risk factors.
- Project Hit began six months ago as a pilot. It is a preventive, proactive program, seeking out families with specific risk factors and contracting with organizations that provide nurse-family partnership. Not doing a traditional investigation, but identifying those families and offering services—crib, food, referrals to other community services.
- Texas has 254 counties, and the relationship between child welfare and law enforcement is different in each one. They do lots of joint training, but Judge Specia doesn't know of any MOUs. They do have MOUs with military bases. They have a strong relationship with the Department of Public Safety, and they will intervene with law enforcement if there is an issue. There are special investigators on staff that are former law enforcement officers. Child advocacy centers all over the state are often housed jointly.
- There are many community prevention efforts beyond child welfare. They provide day

care for foster parents and kinship care providers, as well as high-risk daycare in the family-based safety services program. Other daycare is expensive and often ends up being illegal or inappropriate. The state could definitely could use more daycare services.

- Fewer than 50 percent of the child maltreatment fatalities were known to child welfare. The county just received prevention dollars from the legislature to help address the other 50 percent. They are partnering with the community to do a needs assessment and decide what services they want. Those services will be funded in partnership with nonprofits and foundations.

Congressman Lloyd Doggett

U.S. Congressman Doggett represents San Antonio's South Side and East Side neighborhoods. He serves as ranking member on the House Ways and Means, Human Resources Subcommittee that handles child welfare, child support, foster care, and adoption issues. His Protect Our Kids Act, which President Obama signed into law in early 2013, established this Commission. Last year he was named public official of the year by the National Association of Social Workers and received the Bud Cramer Award. His key points included:

- Although uniformity and precision in the data are important, what is clear is that too many children are dying and we need to focus on what we are going to do about it. The Commission needs to arm elected officials and administrators with the facts to make the case for more reform and more resources as well as share best practices.
- Policy ideas for the Commission to consider:
  - Support funding to reduce caseloads for professionals in the child welfare system, including caseworkers, court personnel, and others. (38% of Texas caseworkers quit within the first year.)
  - Allow federal title IV-E matching funds to be used for preventive services, rather than limiting the funding to after-the-fact foster care services.
  - Support basic parenting training for pregnant women.
  - Encourage collaborative responses, such as those coordinated by child advocacy centers, to protect children.
- An interim report in November might allow Congress to focus on the recommendations when a new Congress begins in January. The recommendations should be strong and unanimous.

Points from discussion with the Commissioners included:

- The Commission should consider making the system more transparent by addressing confidentiality issues.
- There are opportunities with the expansion of Medicaid and the provision of health insurance to address some of the underlying issues affecting child abuse and neglect fatalities.

Judge Peter Sakai

Judge Peter Sakai succeeded Judge Specia as a sitting district judge. He serves on the National Council of Juvenile and Family Court Judges and the Texas Supreme Court Commission for Children, Youth and Families. He also serves on the Texas Supreme Court Commission for Children, Youth and Families. He is also on the Blue Ribbon Task Force with

Senator Uresti. Key points from his presentation include the following:

- When a family comes into the Bexar County Family Drug Court, he sees them as a broken puzzle that requires a team approach to put back together. With this approach, the drug court has had a mere 1 percent recidivism rate.
- What has worked in Bexar County:
  - **Judicial leadership**. The judiciary should be employed as key leaders in the community. Judicial leaders can bring people together to "fix things," especially on a local basis. Judges need continued training through the National Council of Juvenile and Family Court Judges.
  - **Outcome-based programs**. Families need to be rehabilitated and reunited. Bexar County has addressed a significant problem of substance abuse through the drug courts.
  - **A multidisciplinary approach** to address families' complex problems.
  - **Memorandums of understanding** (MOUs). Issues of confidentiality must be resolved through MOUs.
  - **Best practices**. For example, trauma-informed care, as mentioned by Dr. Teasley
  - **Collaboration**. Communities need to break down compartmentalization rules and work across issue areas such as mental health, substance abuse, and domestic violence. Bexar County recently obtained an 1115 mental health waiver that is just going into effect; they hope it will increase local access to mental health services.
  - **Funding**. Communities need to use outcome-based programs to draw down funds.

Laurie Charles, R.N., Christus Santa Rosa Children's Hospital, Texas Child Fatality Review Team

Laurie Charles runs the Forensic Nursing Program at Children's Hospital of San Antonio and Chairs the Bexar County Child Fatality Review Team. Key points from her presentation:

- In Bexar County in 2012, there were 23,476 DFPS investigations; 13 confirmed victims per 1,000 children, 24.5 percent of investigations were confirmed (compared to 23.2 percent statewide); 19 child abuse–related fatalities, 1 in foster care. There are two forensic nursing programs for sexual assault—one for adults, and one for pediatrics.
- What's working in Texas:
  - Texas Family Code allows them to examine a child without parental consent if they are concerned about abuse.
  - Code of Criminal Procedure requires joint investigations between CPS and law enforcement. The forensic nursing program reports to CPS and law enforcement simultaneously. Reporting to CPS and law enforcement supersedes HIPAA privacy concerns.
- What's working in Bexar County:
  - The Center for Excellence at Children's Hospital of San Antonio is run by Dr. Jim Lukefahr and Dr. Nancy Kellogg, who are both participating in this meeting; they are experts in child abuse and are available 24/7 for consultation. They also have direct lines into law enforcement and CPS. They also have a forensic nursing team with more than 60 years of forensic nursing experience.
  - The Center for Miracles is a specialized child abuse treatment center on the grounds of Children's Hospital of San Antonio. It is staffed by child abuse

pediatricians who are specifically trained to assist in determinations of whether something is abuse or not. The Center for Miracles has an American Academy of Pediatrics fellowship program created by Dr. Kellogg. Social workers and a nurse practitioner are also there.

- There are cooperative working relationships among stakeholders.
- DFPS liaisons are housed at all major health systems and at San Antonio police substations.
- At each child fatality review team meeting, they eliminate confidentiality concerns by signing a confidentiality agreement.

Joseluis "Jose" Morales, Night Unit Investigations Supervisor, Texas Department of Family and Protective Services

Jose Morales works from 4:00 p.m. to 8:00 a.m. and sees all child fatality and CPS investigations that come in during those hours. He typically assigns two investigators right from the start, including one who has law enforcement experience. He works closely with law enforcement and Santa Rosa Hospital trauma units and the medical examiner. Key points from his presentation and subsequent discussion with Commissioners:

- One piece that is often overlooked in a child fatality is the emotional component for the social worker. Social workers often have tremendous guilt that stays with them the rest of their lives. It is very challenging to create safety plans with families in those moments. They do have some services, including an Employee Assistance Program that offers free counseling to caseworkers.
- Bexar County also has a Quick Response Team with child safety and risk management experts who review cases to determine where things went wrong and where they can improve.
- Two areas that need greater prevention efforts are safe sleep and drowning. Bexar County currently has a safe sleep poster campaign.
- Another area that needs enhancement is training for frontline social workers on how to approach families in these difficult situations. The relationship with the social worker is key to the family deciding whether to they are going to be receptive to services. Morales does his best to train workers in these areas, but he would like to see more departmental training.

Madeline McClure, Executive Director, TexProtects

Madeline McClure is the founding executive director of TexProtects. Previously, she was a clinical therapist working with severely abused and neglected children at a child advocacy center. She is an appointee to the Texas Protect Our Kids Commission. Key points from her presentation and discussion with Commissioners:

- In Texas, child abuse and neglect fatalities have grown at a rate about three times the average population growth annually. McClure does not believe the recent decline in fatalities is attributable to a prevention program but instead to an informal policy issued from the state through safety specialists, asking frontline workers to use a more stringent definition of child abuse fatalities.
- Texas does not count all cases in which abuse was substantiated and a fatality occurred. Counting all of these deaths would result in a more accurate number. Near fatalities are only included in the fatality count if the child subsequently dies while a

case is still open.

- Obstacles to reducing fatalities:
  - **Flaws in the impact and data collection systems**. (1) It is difficult to collect effective data from social worker narratives, and (2) Many records are expunged after 18 months, which makes tracking of reports impossible and undermines the finding that the best predictor of a fatality is a prior report of abuse. Records should be retained until the youngest child is 18.
  - **Caseloads**. Numbers of investigations have increased, but the other parts of the system have not kept up. For example, family preservation units are overwhelmed.
- Vision for prevention: a multipronged strategy to promote positive parenting and reduce child abuse and neglect fatalities, with a focus on parents of children ages 0–3. These programs would help parents understand child development milestones, utilize the Period of PURPLE Crying programs in the hospital at birth, and employ targeted home visiting programs, especially for high-risk families.
- The expenditure of prevention dollars is negligible compared to the costs of child abuse and neglect. Only 4 percent of those in need get home visiting, and 10 percent of families with the highest needs.

Dr. Kathleen Fletcher, President, Voices for Children

Key points from Dr. Fletcher's presentation include the following:

- Voices for Children is housed in Haven for Hope, a homeless transformation center. Out of several thousand people who came through that center in the last year, about half were formerly in foster care. The child welfare system is clearly not the panacea for most children.
- DFPS is the lead agency for state CBCAP funding. However, there are other prevention programs through the Department of State Health Services, including maternal-child health programs and the Nurse-Family Partnership, which are evidence-based, which could use those funds if there was the flexibility to have more than one lead agency.
- If a fatality is not deemed child abuse and neglect, DFPS cannot follow the family in their next pregnancy or provide the family services in programs that track this. Also, there are near fatalities of children who may live several years but whose lives are truncated and they aren't included in the count of child abuse and neglect fatalities.
- There has been a major increase in child and teen suicides, many of which are escaping severe abuse, especially sexual abuse. These should count as child abuse deaths.
- The United States is one of the only industrialized countries that does not have a universal system of support for new parents, and this plays out in our infant mortality and child abuse rates.

Marta Peláez, President, Battered Women and Children's Shelter and Family Violence Prevention Services

Key points from her presentation:

- Child abuse and domestic violence frequently coexist—68 percent of the families at her shelter have or have had CPS involvement.

- The siloed nature of the system, in many cases, exacerbates trauma. Opening communication between qualified service providers, CPS, law enforcement, the judicial system, health care providers, schools, and churches is critical.
- The Texas legislature mandated creation of a state task force to strengthen collaboration between domestic violence programs and DFPS. Even before that, in Bexar County, Family Violence Prevention Services was working with the children's court to enhance prevention initiatives through collaboration with CPS.

Vicki Spriggs, CEO, Texas CASA, Inc.

Key points:

- There are 71 independent court appointed special advocate (CASA) programs across the state. Texas CASA is a membership organization that provides support, funding, training, and technical assistance. In 2013, 7,611 volunteers provided services to 23,621 children in the child protective system.
- Because of high caseworker turnover In Texas, a CASA volunteer may be the only person who sees a child from the start to the finish of her case.
- Input from CASA volunteers about what works:
  - **Child-centered advocacy**. We must look at problems from the perspective of what will benefit the child, not the system.
  - **Cluster courts** (specialty courts that focus only on family services). Judges in these courts spend more time with children and they are better trained.
  - **Consistency of the assigned worker**. When a caseworker leaves, knowledge walks out the door.
  - Collaboration with all involved parties. This includes the courts, law enforcement, CPS, and CASA.
  - **Culturally responsive interventions.** Create a model and a framework, and people can tweak it to fit their community needs.
  - **Firsthand knowledge of case information.** She has seen guardians ad litem take information from someone else and make it part of their report.
- Of the 156 children who died last year, 14 were in the system. None of them had a CASA.

Joy Hughes Rauls, Executive Director, Children's Advocacy Centers of Texas

Key points from her presentation and discussion with Commissioners:

- Texas has the 68 children's advocacy centers (CACs), the largest network of CACs in the country. The model is based on a multidisciplinary, coordinated approach to the investigation, prosecution and provision of intervention services.
- The key is sharing information. They have MOUs with 800 separate law enforcement jurisdictions, 200+ district attorney's offices, every CPS region in the state, almost every children's hospital, numerous sexual assault nurse examiners, mental health providers, and other hospitals.
- CACs have long been recognized as a best practice model. Two practices are key: CACs themselves have been codified in the Texas Family Code, as have issues around

confidentiality and information sharing. In order to be certified as a child advocacy center, Texas requires interagency MOUs and working protocols.

- About 75 percent of their cases are child sex abuse, but the model also works with serious physical abuse and children who witness violent crimes.
- Intake to a CAC depends on local protocols, but children must be referred by an investigative partner—they can't just walk in. Working with DFPS to capture more cases upstream.
- They do not track cases in a way that would allow measurement of the correlation between their involvement and child fatalities.

Annette Rodriguez, President & CEO, The Children's Shelter

The Children's Shelter serves 4,000 children and families annually, many through residential programs for children who have been removed but also 1,500 families who are looking for prevention services. Rodriguez discussed three programs:

- Nurse-Family Partnership. Discussed earlier. It works.
- Compadre and Compadre. Started in 2009 and now serves more than 500 fathers per year. To date they have served 1,500 dads.
  - All fathers commit to parenting without violence.
  - 54 percent of dads have prior CPS involvement.
  - Results: 100 percent of fathers who have completed the program have not had re-involvement with CPS. 98 percent improved their knowledge and attitudes about being a nurturing parent, and 92 percent increased the quality time spent with their children.
  - After the 15-week program, fathers are able to re-enter the program as mentors. Parent mentors also must be involved with community service.
- I-Parent San Antonio provides respite care for parents.
  - Only respite program in San Antonio and 1 of 2 in the state.
  - Parents are offered respite for up to three days, up to three separate times. Many just need a few hours. They meet with a parent educator, who makes a plan and will work with them for 7 weeks. Big relief for parents to have that support.

Additional points from discussion with Commissioners:

- The fatherhood program uses the Nurturing Fathers Program by Mark Perlman, and assesses participants using the Adult and Adolescent Parenting Index. They do a pre- and posttest on such issues as anger management, quality of time spent with children, etc.
- 50 percent of fathers enter the program as court-mandated participants. The other half are referred by word of mouth and self-referral.
- The respite program is not permitted by CBCAP funding to provide services to families with current or prior CPS involvement. This is a problem; these families are some of the most vulnerable.

Dr. Lisa Pion-Berlin, President & CEO, Parents Anonymous

Parents Anonymous is the oldest child abuse prevention family organization in America. They serve parents, children, and families before and after abuse occurs through their evidence-based support groups and a national parent help line. Their program message is that asking for help is a sign of strength, and they work to build on people's strengths and provide parents with leadership opportunities to advocate for change.

Dakotah Hickle, Parent Leader, Parents Anonymous

Dakotah Hickle told the story of her substance addiction, arrest for child endangerment, and her ultimate reunion with her kids. She attributes her success to the unwavering support of Parents Anonymous, including their support groups and the national parent help line. Parents Anonymous also helped her kids transition back into her home and address their anger toward her. She now wants to help other parents and advocate for prevention resources as a parent advocate.

The Commission then adjourned for the day.

Tuesday, June 3, 2014

FEDERAL POLICY AND FUNDING

Emilie Stoltzfus, Specialist in Social Policy, Congressional Research Service

Emilie Stoltzfus works for the Congressional Research Service, a part of the federal legislative branch charged with providing Congress with nonpartisan policy analysis and information.

- Overall thoughts:
  - A primary responsibility of child welfare agencies is to identify and serve families where children's safety is most at risk. It is narrowly focused because resources are limited and because many people believe the role of government in private family lives should be limited to families in which there is a concern for the children's safety.
  - The limits of the federal government's role have been debated. In the 1997 Adoption and Safe Families Act (ASFA), Congress articulated safety as a paramount concern.
  - Most federal money is provided for removal of children from unsafe homes (foster care) and adoption assistance. Funding to strengthen families is much more limited.
  - The explicit focus of federal child welfare policy on child abuse and neglect fatalities is limited.
- History of federal child welfare legislation
  - The origins of funding sources for child protection include titles IV and V of the Social Security Act in 1935 and the title XX Social Services Block Grant. Title IV began as Aid to Families with Dependent Children (AFDC), and title V as grants for maternal and child health, "crippled children services," and child welfare services. These programs evolved into today's title IV, Temporary Assistance for Needy Families (TANF), title IV-B Child Welfare Services, and title V Maternal and Child Health Block Grant. Title XX's Social Services Block Grant began as an amendment

to title IV, allowing states to provide social services to AFDC families to end their dependence on government entitlements.

  - Ultimately, Child Welfare Services was moved to title IV-B. In 1965, Medicaid was enacted, and in 1974 Congress passed the Child Abuse Prevention and Treatment Act (CAPTA). In 1997, Congress passed ASFA, focusing on the safety of children, including termination of parental rights. The Maternal Infant and Early Childhood Home Visiting Program was created in 2010 as part of title V, which required 75 percent of the home visiting funds to be spent on evidence-based programs. Relevant to this Commission, in 2011 Congress began to require more comprehensive data on child maltreatment fatalities and asked states to describe what data they were using and why.

- Points from discussion with Commissioners:
  - Goals of home visiting programs are to reduce injuries to children, improve school readiness, improve the health of the mother and child, and improve parenting skills.
  - There tends to be a focus on child welfare services, while other federal programs are overlooked including Medicaid, WIC, childcare, etc. These are earlier touch points with children and families and provide opportunities to intervene earlier to assist families and perhaps prevent fatalities.
  - The current structure of child welfare funding incentivizes foster care. There are uncapped entitlement funds for every child who goes into foster care, yet money for prevention services is capped. Billions are spent on foster care, but millions on prevention.
  - The Children's Bureau started 100 years ago to address infant mortality and was very successful at reducing the rate. Title V was originally part of the Children's Bureau and later moved to the Health Resources Services Administration (HRSA) of HHS, separating child welfare and child health. The chief of the Children's Bureau was once a direct report to the President and now is four superiors removed.
  - Committee jurisdiction for CAPTA in the House is the Education and the Workforce Committee, and in the Senate it is the Committee on Health, Education, Labor & Pensions. In the Senate, the Finance Committee has responsibility for child welfare programs, Medicaid, and title V. However, in the House, the Ways and Means Committee has jurisdiction over child welfare, but Medicaid and title V are within the Energy and Commerce Committee. It can be challenging to get committees to collaborate.

- Primary goals of the federal child welfare programs, including title IV-B, title IV-E, and CAPTA, are (1) safety (ensuring children do not experience abuse), (2) well-being (children should have physical, mental, social, and educational development) and (3) permanence, either with their parents or in a new home. Because funding for state or locally run systems comes from the federal government, the government can use the "power of the purse" to set many requirements.

- Federal child welfare funding sources all fall under the Administration for Children, Youth and Families except for Victims of Crime:
  - Title IV-B includes two formula grants to states for child welfare services with some research and technical assistance money—$674 million in 2014.
  - Title IV-E provides reimbursements to states to cover part of their costs for foster care, adoption assistance, and (at the state's option) kinship guardianship and some funds for youth aging out—$6.9 billion in 2014.

- CAPTA: Congress allocated $94 million in 2014 to improve CPS, support CBCAP, and fund technical assistance via HHS.
- Victims of Child Abuse Act (Department of Justice) provides $27 million for CACs, CASA, and child abuse training for judges. This money does not go to state child welfare agencies.
- Note: Title V is the Maternal and Child Health Block Grant and funds state public health agencies. The emphasis is on ensuring good medical coverage for low-income women by connecting them with Medicaid or wrapping around Medicaid whenever there is an issue. It also covers the home visiting program.

- Discussion with Commissioners:
  - An analysis of the total cost of federal spending for child welfare was originally done by the Urban Institute and now is done by Child Trends. In fiscal year 2010, total child welfare spending by child welfare agencies was slightly over $29 billion. About 46 percent of that money comes from the federal government, and 54 percent is from nonfederal (state) monies. The CDC reported a few years ago that the total cost to the public from child abuse and neglect is $125 billion a year. States also make use of other federal funding streams, including TANF, the title XX block grant, and very limited Medicaid funding for special services such as targeted case management, rehabilitative services, and some therapeutic foster care.
  - CAPTA is a "formula grant" and not an open-ended pot of money. States get $50,000 and then it is based on the number of children under 18 years old.
  - Definitions of abuse for substantiation vary from state to state. It has not been determined whether broader or narrower definitions impact fatality rates. The variable definitions make it difficult to rely on or compare numbers.
  - To receive the CAPTA grants, states must make certain assurances to the federal government, including: they are able to receive and respond to reports of known or suspected child abuse and neglect; they can provide a response that ensures the safety of the child; reports will be protected as confidential; there will be immunity for good faith reporters; there will be cooperation among law enforcement, courts, and child welfare agencies. The 1996 reauthorization of CAPTA, among other things, added the requirement for citizen review panels to review CPS work. Then in 2003, health care providers were required to notify CPS if a baby was born affected by illegal substance abuse.
  - Tribal codes exist in many tribes that allow a pregnant women who is known to be using alcohol or drugs to be arrested and incarcerated in the hopes of getting her into treatment. (Unfortunately, this sometimes takes an extended period of time.)
  - The health system can be an important touch point to evaluate families and provide support and intervention services.
- In CAPTA, death is included in the definition of child abuse and neglect and so is subject to reporting laws. Under CAPTA, the abuse or neglect must have been committed by a parent or caretaker, even though neither term is defined. Serious bodily injury is defined in the specific context that states must not require a child to be reunited with a parent who has committed serious bodily injury against that child or a sibling. HHS has not issued any regulations for CAPTA since 1990, and those are considered preempted by Congressional action.
- Definitions and guidance surrounding confidentiality rules are less than clear. Congress reported that public disclosure of fatal and near-fatal child abuse ensures

accountability of the system, and they asked HHS to develop guidelines. HHS did release guidance (not regulations) requiring disclosure of basic information, but then provided for broad exceptions that call into question the clarity of the rule and provisions regarding expungement of records.

- Confidentiality will be a major topic at the next meeting in Florida.

PRACTICE IN TEXAS: PART 2

Dr. James Lukefahr, Medical Director, Children's Hospital of San Antonio, Center for Miracles; Professor, Division of Child Abuse Pediatrics, University of Texas Health Science Center

Key points of Dr. Lukefahr's testimony:

- Several different entities independently decide whether a child death is related to maltreatment:
  - The criminal justice system—the police, DA, and the courts—make a determination that is primarily based on the medial examiner's determination of the manner of death. Purpose: to determine whether a crime was committed.
  - Child protective services makes a determination primarily based on the Texas Family Code.
  - Child fatality review teams (CFRTs) review cases after the investigations are completed for the purposes of aggregating data and identifying prevention opportunities. They too are often driven by the medical examiner's determination.
- Based on their different purposes, each entity may reach a different determination. For example, the 2011 data from CPS indicates 231 deaths due to abuse or neglect, and the CFRT found 328.
- Recent important changes in the medical field:
  - The medical subspecialty of child abuse pediatrics received national recognition through Board certification. (2009)
  - While the national effort to establish Child Abuse Centers of Excellence failed, their standards were adopted by the nation's children's hospitals and the Texas legislature provided funding for Centers of Excellence. (2000)
  - DFPS funded the Forensic Assessment Center Network (lead by Dr. Girardet) to give social workers access to consultations with child abuse pediatricians. (2005)
  - Med Cares is a network attached to children's hospitals and to academic medical centers to fund medical care for victims.
- There is no single database that can give a definitive number of child abuse-related deaths.

Dr. Chris Greeley, Professor of Pediatrics, Center for Clinical Research and Evidence-Based Medicine, Department of Pediatrics University of Texas Health Science Center at Houston

Dr. Greeley focused his testimony on a GIS mapping process being tested in Houston to map surveillance data at the community level to better target prevention strategies. Key points include the following:

- As opposed to NCANDS or CFRTs, this project uses hospitalization numbers for child maltreatment fatalities. When you look at hospitalizations, the data demonstrates that the number of hospitalizations due to child abuse and neglect have actually gone up, not down. Those numbers also demonstrate that infancy is the highest risk period.
- This project uses mapping techniques for each county to find the highest absolute numbers and rates of hospitalizations. Harris County and Bexar County are the two highest areas. If you look at ZIP codes and the demographics of that area, then you have a context for where these kids are coming from and their neighborhood characteristics, which allows you to better target resources and see what protective factors might exist in lower rate areas. They also have mapped by ZIP code the numbers of hospitalizations of abusive head trauma. This effort has taken a public health or population-level approach to identify neighborhoods most at risk for targeting resources, than identifying specific children or families at risk.
- The project's success is attributed to strong multidisciplinary collaboration among universities, children's hospitals, community groups, and philanthropic organizations. Through those collaborations, they can use the mapping data to target approaches based on the risk variables in a particular neighborhood.

Dr. Rebecca Girardet, Director, University of Texas Medical School, Division of Child Protection Pediatrics

Dr. Girardet described a project she is working on with Dr. Lukefahr and others in Houston to address their particularly high child maltreatment death rate and the steep increase in these deaths since 2000, despite a stable population. They set out to determine why. (A variation in counting was ruled out.)

- They began by looking at statewide data, which showed that fewer cases were confirmed in Regions 4–8. Their interest was in "unable to determine" cases, because they suspected that more cases were ruled out for this reason and children were returned to dangerous situations.
- They conducted a focus group with caseworkers in Region 6 and asked why they think they are unable to confirm cases. Many of their responses related to difficulty with medical services: unable to get or understand medical records; unable to get clear or written opinions from physicians as to whether abuse of neglect occurred; physicians won't come to court; caseworkers don't understand medical facts.
- As a result, the project is designing a survey about caseworkers' understanding about the availability and accessibility of medical expertise. The plan is to survey, analyze the data, and come up with local interventions, which will then be implemented and evaluated. They will do four, six-month cycles over two years.
- Texas does have a statewide network of child abuse physicians, which all CPS workers can access. It is easier if they are in a local city and can schedule an appointment or they have a web-based system where they can submit documentation and then consult with a physician.

Commissioner Questions and Discussion

Issues and questions raised by Commissioners in response to the three doctors' presentations include the following:

- None of the doctors could give a definitive explanation for the precipitous drop in the

number of deaths, according to DFPS numbers. Their suspicion was that it could be a change in definition or something clerical. Pediatric hospitalization and discharge data do not show much variability during the same timeframe. Some of the possible explanations raised by a Commissioner were: statistical variation (but unlikely because the trend has been consistently downward), workforce threshold, CAC system, expansion of child abuse pediatrics, quality improvement projects like Dr. Girardet's, better success with treatment of abusive head trauma, economics, and population health strategies. Other possible explanations include the infusion of resources in about 2008 and the expansion of pediatric trauma centers—kids may be getting into pediatric intensive care units faster and getting better care.

- Panelists indicated that their role as child abuse pediatricians varies among localities, from resolving a discrete issue that brings a child in, to becoming a family's medical home. Most kids who come in are referred by a hospital. Some centers may have specific specialties, such as sexual abuse.
- Funding for child abuse pediatrics and child protection teams in general is a big challenge, because the vast majority of kids only have Medicaid—and some don't even have that. Even if the child does have insurance, it does not cover a pediatrician testifying in court or going to meetings with CPS workers. This role is very time consuming and there is no way to cover costs with a traditional medical billing model. Psychological care is even more challenging because it takes more time to bill Medicaid than it is worth. You must have additional funding to provide these needed services.

Judge F. Scott McCown, Director, Children's Rights Clinic, University of Texas Law School

Judge McCown began his presentation advising that caution must be taken in drawing any conclusions about the Texas drop in child abuse deaths. The smaller the mortality rate, the more difficult it is to distinguish actual change from random fluctuations. It is not clear that something systematic happened. Further, it is a mediated number. The judge offered three recommendations:

- The study of child deaths should be separate from the determination of child maltreatment. With respect to child death, the analysis is from a public heath perspective: why is it happening, how do you prevent it, and how do you avoid recurrence. With respect to child maltreatment, you are determining a parent's culpability and whether the state should intervene. Public health questions are broader and require a change in normative values before an action is considered neglect. If the public health question is separate, we need to build a system separate from culpability and from state child abuse and neglect laws.
- Agency confidentiality should be distinguished from public transparency. Deaths do not lead to calls for improved systems or higher taxes. The response is, "who should be fired?" Like the medical peer review model, there should be complete transparency regarding child death review, but that doesn't necessarily mean total public transparency.
- The Commission needs to call for funding for fundamental reform. Fatalities are in many ways a random consequence of the larger problem of child abuse and neglect. The concern should be for all children whose lives are seriously damaged by abuse or neglect. The solution must include fundamental reforms such as flexible funding and more funding for prevention services.

Dr. David Lakey, Commissioner, Texas Department of State Health Services

Dr. Lakey's presentation focused on three main areas:

- The importance of providing timely data. State and local child fatality review teams are a multidisciplinary public health strategy to understand risks to children. That review needs to be timely (sometimes delayed over a year), and teams need more resources to review all deaths across the state.
- The role of substance abuse. Untreated substance abuse issues of parents are a direct threat to children's safety. Prescription drug-related deaths are more prevalent than deaths related to any other drug. The delay in getting parents into treatment is a major barrier to healing families. Last year the state legislature gave the department $10 million to ensure there was no wait for treatment.
- The importance of providing education to frontline physicians so they can recognize when something is wrong. The Dept. of State Health Services works through Texas Healthy Steps, their Medicaid program, to provide comprehensive preventive health services for individuals from birth to 20. There is online provider education to help providers appropriately identify issues and refer into this system.

In response to a Commissioner's question, Dr. Lakey described how he has expanded substance abuse treatment in Texas by making it a Medicaid-eligible service.

William McManus, Chief, San Antonio Police Department

Chief McManus focused on the idea that the police address the aftermath of child abuse. They do a good job with arrest, prosecution, etc. They also see their role as public educators, by encouraging the public to report abuse and by participating in PSA's. He suggested the need to expand resources to parents for basic childcare education.

In San Antonio, police will accompany a child welfare worker on an investigation, if requested.

Krista Melton, Assistant Criminal District, District Attorney of Bexar County

Krista Melton appeared representing the elected district attorney, Susan Reed. Melton is an assistant criminal district attorney who has worked in the Family Justice and Victim Protection Unit for approximately 14 years. Key points from her presentation:

- The DA's office typically gets involved with a case at the time of arrest. One of the most important resources for her is the Center for Miracles (their CAC). Their doctors play a critical role in the charging phase, postindictment investigation, and trial testimony.
- Legal changes she would recommend:
  - Create a continuous physical abuse statute comparable to the continuous sexual abuse of a minor law, which allows prosecutors to charge more than one victim in one indicted count if the defendant committed two or more acts of sexual abuse in 30 days or more, if the child is under the age of 14.
  - Pass a child torture statute. This statute would allow certain cases that may ultimately lead to a fatality to be charged more significantly, possibly preventing a death.

- The DA's Office also has been part of the Child Fatality Review Board and as a result has been involved with water safety campaigns.

Commissioner questions and discussion:

- There was discussion regarding the connection between child abuse and human trafficking.
- Melton recommended enhanced communication between jurisdictions about criminal history as well as CPS history, to address abusers and traffickers moving from one jurisdiction to another.
- In Texas, there are criminal statutes for injury, which could include pain, illness or impairment, or abandonment/endangerment. There are no criminal statutes for neglect per se. A pattern of neglect would be something that could be covered by a torture statute.

Dr. Jolyn Mikow, Faculty, University of Texas at San Antonio, Department of Social Work in the College of Public Policy

Prior to entering academics, Dr. Mikow was a direct service social worker and supervised workers who experienced child deaths. She made two recommendations:

- Funding of meaningful prevention and early intervention programs must be a priority and not the first thing to be cut. Often intervention by CPS after a report is after the window of opportunity for that family—prevention needs to be real, not a sliver in a budget.
- Title IV-E social worker educational stipends need to be better utilized and have full funding restored. A little known part of title IV-E can fund employees and students to get social worker degrees, and they are committed to the public child welfare workforce. This creates a more experienced, committed, stable workforce.
- In discussion with Commissioners: One area that needs improvement in Texas and nationally is the understanding of what it means for a program to be "evidence-based." There are higher and lower levels of evidence.

Reverend Dr. W. Raymond Bryant, Pastor, Bethel African Methodist Episcopal Church

Reverend Bryant discussed two main areas of concern:

- The law does not distinguish between a neglectful parent who is doing everything she can within her limited resources, and the drug-addicted mother who leaves her child alone to go smoke crack.
- A metaphor for possible responses: If someone is at the top of the cliff, you can either put a fence at the top to keep them from falling off or put an ambulance at the bottom. The Reverend expressed his hope that the Commission will build more fences at the top. Communities need to have places where parents can go for help.

Clarissa Zamora, Director of Education and Outreach, ChildSafe

Clarissa Zamora represented ChildSafe, San Antonio's local child advocacy center. She described the educational programs that her organization is putting on to train school districts, YMCA workers, Girl Scouts, and other groups to recognize and respond to child abuse. They

also are providing a child empowerment safety course, RAD-kids (Resisting Aggression Defensively).

James Castro, CEO, St. Peter-St. Joseph Children's Home

James Castro described his 14-day model of healing, which he believes can heal children from trauma they have experienced and reduce poor outcomes for children in foster care. The major components are:

- Treat the trauma issues associated with abuse and neglect with the same urgency as physical trauma.
- Agencies need access to the biological family to understand the child.
- All assessments by therapists and caseworkers must be completed by the 10th day.
- Create a global intervention plan that doesn't just get the child a therapist but finds interventions that are going to help develop the parts of the brain that have been impacted by abuse and neglect.
- Empower the caregivers—foster families, biological families, relatives, and adoptive families. The plan needs to follow the child.

A discussion with Commissioners followed regarding how the community comes together to overcome politics and treat these families. Castro sees home-based services as an important component. Agencies need to be able to get inside the home to develop relationships and provide services. Then the big question is how to take it to scale.

Melissa Stoeltje, Social Services Reporter, San Antonio Express-News

Melissa Stoeltje has covered social services, including CPS, for the last several years. She began her presentation by acknowledging the respect she has for CPS workers, all the way up to Commissioner Specia.

The main challenge Stoeltje faces in covering CPS is the department's confidentiality policies:

- The only material CPS is required to release is a child fatality report called a 2059. This bare-bones report contains only basic information and does not give a true picture of the family's interaction with the agency. Often even this is not available right away, sometimes for weeks. Reporters must rely on whatever the public relations officer discloses.
- Stoeltje illustrated the need for in-depth information with a tragic story of an 8-year-old who died of medical neglect after there had been significant history of the family with CPS. Senator Uresti conducted an internal review, but she believes this resulted in a "toothless" recommendation that employees need to understand policy. Ultimately, Stoeltje gained access to all the records and was able to tell the whole story of the case, which involved a significant number of referrals, lack of parental cooperation, legal challenges, and administrative reviews. Now the Inspector General has opened a case and his investigation is pending.
- Confidentiality policies end up protecting CPS and not the privacy of children and families. They allow CPS to police itself.
- Upon the death of a child, all records should immediately be released (with redactions

regarding siblings or other legitimate concerns, if necessary).

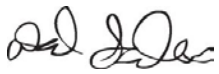
Commissioner discussion: How can the media can write their stories in a way that creates a will to create change. Stoeltje replied that her intention is to motivate change and get the attention of the legislature.

CLOSING REMARKS

Chairman Sanders

Chairman Sanders concluded the meeting by thanking the speakers, those who attended in person and by phone, the media, Congressman Doggett and his staff, and the Commission staff. The next meeting will be held July 10 in Tampa, Florida, and will include a focus on confidentiality.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.



David Sanders, Chairman, Commission to Eliminate Child Abuse and Neglect Fatalities

September 2, 2014
Date